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# An Outline for Working with the Hearing Impaired in an Inpatient Substance Abuse Treatment Program

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# AN OUTLINE FOR WORKING WITH THE HEARING IMPAIRED IN AN INPATIENT SUBSTANCE ABUSE TREATMENT PROGRAM

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**I. Deafness: Not just a handicap – Culture.**

Six to ten percent of the population in the United States today has some type of hearing impairment. Hearing impairment occurs at all ages and ranges from mild impairment to severe, profound deafness (Stewart, 1982). Possibly the largest subculture in America consists of deaf people who use Ameslan, or American Sign Language, as their native language (Humphries, 1983). There is not a different culture for wheelchair users or the blind. Why then, is this disability group so different? Exactly! The deaf as a disability group *are* different. This is the premise of the following paper.

There is a separate culture for those deaf persons who use American Sign Language (Humphries, 1983). Language is the bearer of culture. If you and I do not share a common language, then we grow apart culturally. If we cannot talk to each other in a way we both understand, we cannot communicate. Because of this phenomenon, deaf people are very different, culturally, from hearing people (Bolton, 1976). This group of persons, who are culturally and linguistically deaf (using American Sign Language), are the focus of this paper and are denoted by the term (D)eaf.

**II. Is deafness soley a problem with auditory functioning?**

Deafness does not impact the sense of hearing nearly as much as language (Mindel and Vernon, 1971). The deaf person cannot hear speech. Although this is problematic, it would not be so handicapping if one could acquire language naturally, easily, without the ability to hear. The deaf child does not develop language equivalent to that of a three year old until five or eight years of age (Mindel and Vernon, 1971). This is due to numerous linguistic, educational, and developmental factors. The fact remains, it is rare that a deaf person *does not* have significant language development delay (Goldenson, 1978).

Take for example the concept of "disease". Explain it to the average alcoholic. You start with the premise that when you say the word "disease" there is comprehension of the concept. The deaf person may not even have a definition of the word. Well, alright, then tell them it is a collection of symptoms caused by a virus or condition. Excuse me, explain the meaning of the words "symptom", "caused", "virus", and "condition". Well, simple enough, a symptom is something that shows you are ill. Explain what you mean by "shows" and "ill". Get the point? An alcohol/drug rehabilitation program must first teach language to satisfy the needs of deaf participants. Then, using the language base established, one can teach the concepts about addiction, which prove so liberating to the compulsive abuser.

This kind of education process may bog down the hearing group. If at all possible, search out a consultant/counselor who knows sign language, is familiar with the deaf culture, and hire this person to act as primary therapist to your deaf patient. This person can prepare the deaf patient in individual sessions with the language education necessary to effectively utilize the program. If this situation is not available, then the counselor can arrange for one-hour sessions with the patient. These sessions should be in addition to personal and group counseling. Using an interpreter to facilitate the communication between them, the counselor can work on establishing basic langauge concepts with the deaf patient.

The primary counselor should educate the hearing impaired patient prior to the specific lecture or group setting. If the Deaf patient is having problems comprehending lecture material, provide a simplified explanation, then refer him to the primary counselor. Make a note and be sure the primary counselor knows to reinforce the concept or idea missed. Using some

group time to incorporate the deaf person can be advantageous even to other group members. They learn tolerance and may even get clarification when afraid to ask the "dumb" question. Be wise: don't include the deaf person at the expense of the entire group; similarly, don't think every question needs in-depth linguistic explanation.

### III. Alcoholism/Addiction the lonely diseases; Deafness the lonely handicap.

Alcoholism has been called the lonely disease (Coleman, Butcher, and Carson, 1980). Interestingly enough, deafness has also been called the lonely handicap (Mindel and Vernon, 1971). Why? What child's mother, most of the time, cannot speak her child's native language (Mindel and Vernon, 1971)? What other child with loving mother and father will not have meaningful communication with them until age eight or twelve? What child will be excluded from family fights, discussions, decisions? What adult has little or no meaningful communication with his family, his employer, his co-workers? The deaf child, the deaf adult does not.

Language impacts deaf persons severely, isolating and excluding them from normal interactions with the world. The deaf alcoholic has, then, a multiplied problem. He must overcome the limiting effects of a disability (deafness) and a disease which encourages isolation. The integrated alcohol treatment program highlights the isolation so much for the deaf alcoholic/addict, the hope that recovery could offer can be masked. Awareness by the treatment staff and a primary counselor with proficiency in sign language can lessen the potential negatives while taking advantage of all the positives.

Regardless of whether a signing primary counselor is available, it is imperative that the program counselor contact Alcoholics Anonymous, arrange for deaf alcoholics or other alcoholics who can sign (hearing) to meet with the deaf patient. This will take some work as there are *VERY FEW* recovering deaf persons. Contact as many sources as you can, while being cautious not to break confidentiality. From my experience, the deaf patient who has met with at least two other signing/deaf alcoholics before leaving treatment, has greater potential for success than a patient who has no sign language using AA contacts.

It is important to point out some Deaf persons interact well with hearing patients, others do not. The patient who does not integrate with the hearing patient community may afterwards feel more isolated and different than before treatment. This isolation clearly defeats the purpose of treatment. If the deaf patient is not interacting well, consider an early discharge. Many times I advocate for early discharge for several reasons.

First, the hearing patients and staff consider it a novelty in the beginning of treatment and reach out to the deaf patient. At about 10 to 20 days into treatment, the novelty wears off and the interaction decreases markedly. The patient senses this natural process, feels objectified, and begins to isolate himself.

Secondly, the cost of funding a deaf patient is high. For this reason many treatment programs provide an interpreter only part-time. This tends to leave the deaf person alone or uninvolved too much. As the days pass, the patient notices more the time he misses the interpreter than has one. Consequently, the patient feels increasingly isolated. I advocate for 4-6 hours per day of interpreting, for shorter periods of time. For example: 15 days with interpreter services for 4-6 hours per day, is preferable to 28 days with 2-3 hours per day of interpreter services. This utilizes the interpreting time more efficiently and helps to increase assimilation of information.

Thirdly, the nature of sign language and language delay creates a special situation. The deaf patient, like the hearing patient, is learning new words and new ways of thinking about an old problem. For the deaf patient this process is more complicated. He must first learn a new word, then a new sign for that word, then a meaning for that word. Meanwhile his hearing counterparts are "merely" learning new meanings for previously known vocabulary. Any mind can assimilate only so much extensive language education. The deaf person can quickly experience overload. Optimally, the deaf person should enter treatment in the beginning of the treatment cycle when concepts are first being introduced and stay only until overload starts. The deaf patient genuinely needs more time to assimilate information.

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**IV. Interpreters: A matter of trust.**

Ideally, an interpreter is a person who becomes involved in a situation where two parties do not understand each other. These parties need someone to convey their ideas to each other, because their language differences create a barrier. The sign language interpreter bridges the gap by conveying the deaf person's signs into spoken language and the hearing person's words into signs (Caccamise, et al, 1980). There are three groups of people who use sign language. They are deaf people, signers (those who know sign language), and interpreters.

The second group I mentioned are signers. These individuals have learned sign language because of association with deaf people or personal interest. DO NOT use a signer in lieu of an interpreter. They are not trained in interpreting, only in sign language. Let me give you an analogy. Using a signer to do the job of a qualified mental health interpreter is like asking a life guard to do surgery. Be aware; signers often mean well and are willing to provide the service free, but in the end are very damaging to long term success. Frequently these volunteers are very enthusiastic; use them to assist with written assignments or driving the deaf person to a meeting – NEVER AS AN INTERPRETER!

Interpreters may be certified by a national agency, the Registry of Interpreters for the Deaf. To be certified, these interpreters have undergone an evaluation. Due to certain circumstances, the number of certified interpreters (those who have passed the evaluation) available is very low. You may need to use an interpreter who is not certified by the RID. This non-certified interpreter, nonetheless, should have verifiable credentials such as a certificate of completion from a reputable training program. Usually, you can get a qualified interpreter from a social service agency in your state.

There exists, in most states, a crisis in the interpreting field. The number of qualified interpreters has not kept pace with the demand. For this reason, it is imperative that the arrangements for the interpreter be made in advance of the patient's admission. Sadly, I have seen patients, left alone without an interpreter, become frustrated and leave treatment. Arranging payment for the interpreter, scheduling the interpreter, checking qualifications, and any staff orientation/in-service must be done PRIOR to admission. The misunderstanding, disappointment, frustration, time, and dollars this saves cannot be understated.

The interpreter does not interject opinions, personal ideas, or thoughts, but allows the communication to remain a pure exchange. The interpreter is to keep all information confidential since the interpreter would not be needed if the person involved were not deaf or the hearing person knew sign language. This is the function of an interpreter. Now, let us discuss some history.

Interpreters' reputations for being trustworthy, competent, disinterested parties has been, up to now, generally poor. Interpreters, until the last fifteen or so years, were primarily children of deaf parents and members of rather conservative religious sects who felt it their mission to reach the deaf (Lane, 1984). One possible explanation for this poor reputation is that children of deaf parents have very similar behaviors to adult children of alcoholics (Greenberg, 1970). They act as protectors and parents to their parents (Greenberg, 1970). When these individuals were brought into an interpreting setting, it is easy to see that the communication usually did not remain a pure exchange, but was colored by the interpreter's "best" wishes for the deaf person or parent (Greenberg, 1970). This situation created mistrust of the interpreters, the person who was being interpreted, and the hearing world in general.

Another option was to use church interpreters. Can you see how certain thoughts and behaviors might influence the exchange? Consequently, interpreters were mistrusted and disdained. Things have changed radically in the interpreting profession; however, history is slow to be forgotten. Therefore, it may require as much time for the deaf person to trust the interpreters, as the counselors, or non-signing group members (Boros, 1983).

To minimize this trust factor I recommend using as few personnel as possible. It is better to postpone admission for one or two weeks to locate an interpreter who can do all the group therapy sessions or all the lectures. Forethought and planning can radically decrease the confounding created by this trust factor when working with the deaf alcoholic.

**V. One-to-One.**

The deaf person in a one-to-one setting is

much like the non-impaired person. There is a heightened sense of body language and the added frustration of needing to communicate in one or the other's non-native language. For example, the deaf patient is communicating by using written English; the hearing counselor is trying to understand written American Sign Language. Consider the same things you would do with an able-bodied patient. Show empathy with your body, actively listen, use the language level of the individual, be open and honest.

Initially you may feel uncomfortable, especially if an interpreter is present. Talk about this with other staff members, and be honest with your patient. Your level of comfort affects the counseling process, so be aware of yourself. The interpreter may want to sit behind you. This can be unnerving if you use a desk. The interpreter is the expert; let him tell you where to sit. There are important, practical, linguistic reasons for what they do and say. Do as they instruct you and the situation will flow smoothly.

Due to the nature of deafness, the deaf patient may touch you more often than you are accustomed to being touched. Are you taken aback by a hug or touch? This physical contact is an important, vital means of communicating for the deaf. The deaf patient may feel you are not listening to him if you do not maintain direct eye contact. Look at the patient, not the interpreter. Use natural gestures, pantomime, written notes, pictures, whatever it takes to get communication across.

**VI. In a group.**

Groups can be more difficult with a deaf member. It is usually best to excuse the deaf person from groups where no interpreter is available. When you cannot excuse the deaf patient from an uninterpreted lecture, use the chalk board and write down as much as possible. Have a volunteer sit next to the deaf person and summarize what's going on. Encourage the deaf person to sit in the front. Some films are accompanied by scripts; locate these and provide the deaf patient a copy. Do not walk around or obstruct your face with drinking, smoking, or hand movements. Encourage group members to share their notes with the deaf member. He cannot write down information and try to speechread/watch what's going on at the same time.

Be cautious about choosing the volunteer. Women are especially prone to rescue, to the detriment of their own treatment. Make sure you rotate volunteers so one individual does not begin to resent the deaf member. Watch out for people using the deaf person as a means of defocusing from their own disease.

If an interpreter is present, allow the interpreter to choose the best seat for himself. the interpreter will help the situation flow smoothly if allowed to do so. When showing a film, consider the deaf person's need for additional light; ask the interpreter how to handle the problem. Include the deaf person. Allow him to make comments. Expect these comments to take a bit more time as the individual is working through an interpreter or by writing. Do not expect the interpreter to share his feelings. He should not give any comments or ask questions. Try to remember this fact; if the deaf person were not deaf, the interpreter would not be there.

**VII. Generals about linguistics, lip reading, and speech.**

Generally deaf individuals do not have a firmly established English language base (Mindel and Vernon, 1971). They have acquired language in a much different way than their hearing peers. Gaps may exist in their ability to adequately read or write the English language. If they don't understand the material the first time, re-word the information, or simplify it. Accomplish this without resorting to infantile, condescending language. Knowledge of English as a second language has little to do with intelligence. Do not patronize these patients. Remember, this is an adult.

Generally, deaf persons' lipreading skills will not suffice to understand speech. Deaf individuals, in fact, do not "lipread", they speechread (Northcott, 1976). They use facial expression, gestures, and lip movements to "read" speech. Speechreading for the average deaf person is an ineffective way of assimilating what is being communicated. Only thirty percent of speech sounds are visible on the lips. Low visibility of English and confounding factors (facial hair, Brooklyn accents, smoking) make speechreading a cumbersome task for most deaf persons.

The ability to speak can be taught – to a degree. Deaf people's ability to speak may vary widely. Some can be clearly understood, some

are understandable to a trained ear, others hardly at all. Most deaf persons were mercilessly teased bout their speech as children. This is the historical basis for many deaf adults' decision not to use the speech they have. A point of great trust is the day a deaf person uses his speech with a counselor. *Do not press this point!* If the deaf client chooses to use his speech allow the individual plenty of time to develop the necessary trust.

Several other aspects of deaf culture often frustrate the person new to deafness. First, the structural presentation of American Sign Language differs from English (Stokoe, 1978). English speaking persons who can hear normally move from specific to general. You and I make a point, then support it with personal anecdotes and facts. the culturally deaf person moves from general to specific. The patient will first support his point, then make the point (Marcowicz, 1973; Bellugi, 1972, Padden, 1984). This is sometimes misconstrued as defocusing or denial. Watch out, give the deaf individual more time than the hearing person to make his point. I am not saying that deaf patients never defocus or experience denial. I do mean their way of expressing a point is different and more time consuming (Bellugi, 1972). American Sign Language takes longer to terpret and the beginning coming last, can make one feel like you never get to the point (Meadow, 1972). Be patient. *Expect the deaf patient's input to take three to five minutes longer than his hearing counterpart*. Enjoy the wait, it will be worth it (Jacobs, 1977; Marcowicz, 1972).

Lastly, the deaf community is very small. Partly because of this fact, once branded a drunk, always a drunk (Stewart, 1982; Cordero, 1982). This characteristic proves very damaging to the deaf alcoholic's hope for change. The deaf community remembers and still believes all the old wives' tales you and I did 30-50 years ago. The deaf community still maintains weighty moral judgments about drinking and drinking behavior. These attitudes, because of the flow of information (primarily word of mouth/hand), remain the same while the larger hearing societies' have changed.

There are many reasons for the deaf community's seeming gossip. For many years, oral communication was the only way daily news and community events could be shared. This knowing everything about everyone is also linguistic. Sign language is the only language where one can "listen" to an entire conversation from across the room, unbeknownst to the speakers. It is an easy language upon which to eavesdrop.

In still another way this openness helped police the community. Hearing people who hurt the deaf were branded; interpreters who gossiped were blackballed (Lane, 1984). The deaf alcoholic usually feels helpless to change his image within his community. I suggest this idea be challenged gently during treatment. There exists a new recovering deaf community, microscopic but growing. This group understands, with forgiving memories, the pain of judgments and labels. This may be the most liberating truth the deaf person will hear in treatment. Old painful memories soften slowly, so confront gently.

### VIII. Conclusion

In conclusion, the recommendations this author makes: 1) To understand the deaf as a culturally different group. 2) To respect that difference and via respect potentiate better treatment success. 3) To use a paid, qualified sign language interpreter to facilitate communication for the length of the treatment. 4) To check references, arrange payment, and schedule interpreter services for both patient and family prior to admission. 5) To use the minimum number of interpreter personnel possible, preferably one interpreter for the duration of the inpatient stay. 6) To use a primary substance abuse counselor who is either deaf or fluent in American Sign Language and deaf culture. 7) To get the deaf patient in contact with any and all recovering deaf or sign langauge using persons prior to dischage. 8) To expect to teach more basic language concepts to deaf patients. 9) To watch for signs of isolation and discharge early if necessary.

Treating a deaf patient in most other respects is the same. The grief and loss process, family dynamics, and the denial cycle are all there, just silent. It is possible for the deaf patient to gain recovery and abstinence. This can be easier if you will consider the points offered in this paper. These sugestions have been formulated by observing the trial and error of programs attempting to treat the deaf. In the hope you need not repeat the error, this paper was

birthed. File it somewhere, and should you get to work some Saturday, pull a chart that says "PATIENT IS DEAF!," don't forget where you put it.

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